MONTANA STATEWIDE HEALTH COORDINATING COUNCIL

REPORT ON THE 1982 GOVERNOR'S CONFERENCE ON MEETING MONTANA'S HEALTH CARE NEEDS

JANUARY 1983

Montana Statewide Health Coordinating Council

Bureau of Health Planning and Resource Development
Montana Department of Health and Environmental Sciences

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Report on the 1982 Governor's Conference

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January, 1983

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January 10, 1983

Honorable Ted Schwinden
Governor of Montana
State Capitol
Helena, Montana 59620

Dear Governor Schwinden:

The Statewide Health Coordinating Council has prepared the following report as a part of our responsibilities as your advisory council on health issues in Montana. On behalf of the Council, I thank you for your support for the 1982 conference.

The willingness to participate and spirit of cooperation shown by Montana's leaders, including consumers, providers, and public officials, made the conference an educational and productive experience for all concerned. We have put the results of the conference together with our experience in analyzing Montana's health issues and preparing the State Health Plan to provide you with the recommendations of this report. The recommendations are from the Council, but we believe they represent a consensus of Montana views.

Along with my fellow Council members, I am looking forward to working with Montana's people to further refine and implement policies that will keep our health care system strong and effective.

Sincerely,

J. Melvin Williams

J. Melvin Williams, Chairman
Statewide Health Coordinating Council

POLICY RECOMMENDATION

The Council recommends the following policy statements be used as guidelines in the consideration of health issues by all branches of Montana's State government:

1. Responsibility to the Public.

Health care is not exceeded by any other State responsibility as vital to the present and future of Montanans. The State has an obligation to ensure that each individual has an opportunity to receive health services--an opportunity that is not hindered by discrimination based on race, age, sex, religion, or national origin.

Individual responsibility for health should be encouraged. This individual responsibility should be supported by a health care delivery system that is as efficient and as effective as possible. State resources for health should be used in ways that encourage individual responsibility and efficient delivery of effective health services. Reallocations in health funds may be needed. Additional funds may have to be considered after evaluation and improvement of the State's current use of health resources.

2. Provision of Services.

Health protection services, including public health and environmental services, are the responsibility of the State. This responsibility may be shared with national and local governments, but the State has primary responsibility in this area.

Health promotion and disease prevention that can be accomplished through the actions and life-styles of individuals remains as an individual

responsibility. The State responsibility in this area is to encourage and coordinate the efforts of volunteer groups, public health and private health care providers to educate and assist individuals in ways to promote and improve their health.

Personal health care services are available through a variety of independent health care providers. The determination of what services are necessary is a matter that must continually be updated and negotiated among health care providers, health care consumers, and public representatives. How the State determines whether or not an individual has the ability to pay for necessary services is a matter to be negotiated periodically by Montana's citizens through State government. Once these determinations are made, the State should provide funding for the care.

The State must assume responsibility for those services that individuals are not able to provide for themselves to protect, maintain, and restore health.

3. Distribution of Services.

The State should assist communities in determining what services are to be provided locally. Within the limits of financial constraints, public protection, and viability of service units, these determinations should be made locally. Specifically, the State should encourage and assist local communities in assessing their health care needs and resources.

4. Health Care Costs.

State government has the responsibility to take necessary actions to maintain a three-way balance among health care costs, quality of care, and accessibility to care. The State must not consider these as three separate areas of responsibility but must adopt programs that promote the public interest in all three areas.

RECOMMENDED ACTIONS

1. The State should maintain funding of programs protecting the public from health and environmental hazards.

2. The State should maintain funding for coordination and encouragement of health promotion and disease prevention programs.

3. Programs to address special health needs should not be established by State law if they are not funded through the State. This would include Federally-funded programs with no long-range commitment to continued support.

4. The State should maintain the capability to assist local communities in assessing their health service needs.

5. The State should assess the need for funding or providing transportation for routine health care as an alternative to expansion of services, unnecessary use of ambulances or home health care, or some individuals going without needed care.

6. The State should maintain its Certificate of Need program as a control on capital expenditures for health care facilities and equipment and as a means of maintaining equitable distribution of facilities. The program should be improved to provide a shortened appeal process, increased thresholds for inclusion and equal application across all providers.

7. The State should consider a mandatory rate regulation system for prospective reimbursement for health care services. The system should have the following characteristics:

(a) It should establish rates prospectively and both service providers and all payers should be held to those rates.

(b) It should be administered by a commission that would be independent of both health care providers and State government.

(c) It should be staffed by an agency that would be established specifically for carrying out the rate regulation functions.

(d) It should be funded through State government either by general funds or specific fees to service providers and third-party payers.

(e) It should apply to hospitals, nursing homes, and home health care services. Other health care services should be evaluated for possible inclusion.

(f) Each service included in the system should be required to have a formal peer review system and the peer review system should report annually to the rate commission. The rate commission could also use the peer review group to help evaluate the quality of care impact of the rate structure.

8. The Governor should instruct the Statewide Health Coordinating Council to hold a 1983 Governor's Conference on Health. This conference should evaluate the year's progress on meeting Montana's health care needs and revise and elaborate on policies and actions for the future.

Reports from the 1982 Governor's Conference

on

Meeting Montana's Health Care Needs

The Conference was held on September 27 and 28, 1982, in Helena. Participants representing a variety of statewide consumer, provider, and government organizations were invited. Each conference participant was assigned to one of four groups. Each group was given a Montana health issue to discuss and given the assignment of making recommendations for policy and action on that issue.

The groups were asked to start with the following assumptions although the assumptions could be challanged by the group if they felt they were not accurate:

1. *Access to health care services can generally be considered adequate in Montana at the present time.*

2. *Montana has quality health care appropriate for today's standards.*

3. *Maintaining and improving health care quality will require increased expenditures, both public and private, or some form of rationing of services.*

4. *Montana State government can best serve the public interest with respect to health if there exists a clearly-stated health policy developed through participation of affected persons and groups and used as a guide for decision-making by public and private participants in the health care system.*

The following group reports include (1) a statement of the discussion question, (2) the report as presented by the facilitator for the group, and (3) footnotes added by the SHCC to provide their interpretation of, or reaction to, the group report.

GROUP I ISSUE

What is Montana's responsibility to assure health care for its people?

a. Do each of us have a right to health care?

b. What is Montana's responsibility for services to:

-- the general population
-- the indigent
-- the elderly
-- other special groups

c. How should priorities for state health care expenditures be determined? Who should participate in these decisions?

d. Are there serious problems or inequities in Montana's current use of health care resources?

e. If Federal and local health care funds are not adequate to maintain current services, should the State reduce services, increase taxes, shift funds from other uses, or use some combination of these approaches?

GROUP I REPORT

POLICY STATEMENT:

Health care is not exceeded by any other State responsibility as vital to the present and future of Montanans. It is the State's obligation to respond to public mandate and to reconcile needs with resources. Each Montanan should be guaranteed access to basic quality health care services. The State has an obligation to ensure that each individual has an opportunity to receive health services - an opportunity that is not hindered by discrimination based on race, age, sex, or national origin. Individuals have the responsibility to assume responsibility for the costs of health care within the limits of their income and resources. The State should not provide funding for health services to individuals who are able to provide their own. Those with no immediately foreseeable means to pay for the necessary, basic health care services should have these services funded by the State. 1/ 2/

The State must take a leadership position in establishing communication, education, and coordination of all concerned. As part of its leadership role, the State needs to hold the Federal government accountable to its responsibilities regarding programs the Federal government initiated and from which it withdraws funding support. All new Federal programs offering seed money to start should be carefully examined by the State to assure that future need and funding can be met by the State and local governments, consumers, and providers. In defining funding levels, reimbursement must meet costs. There should be consideration of alternative reimbursement structures; e.g., tax incentives. As a first step in meeting funding crises, programs must be evaluated and prioritized. State solution of needs by programs must consider prioritization and existing funding, and, if necessary, increased taxation. Delivery systems must become more efficient without losing effectiveness. There should be increased coalescence between providers, consumers, and the State.

1/ The SHCC interprets this to mean that if there is a public mandate, the State must respond to it and, in so doing, must reconcile needs with resources.

2 The SHCC calls attention to the fact that this paragraph is primarily concerned with financial access to health care. The reference to "basic quality health care" is subject to interpretation and would be better stated simply as "health care."

The following is the response to two of the subquestions:

a. *Do each of us have a right to health care? We have a guarantee to access to basic quality health care services. The categories include the following:*

Quality Standards, Public Health Hazards, and Environment. The State's obligation is to ensure that changes need to stay contemporary and that the best that technology can provide be balanced within the economy.

Under Communicable Disease, we included immunization, accessibility, identification, and picking up where other resources leave off.

Under Dental Care, such things as early screening, referral, education, fluoridation, and recruitment were included.

Under Acute Care, we have necessary need, physician involvement, communication, follow-up, and standardize procedures.

Chronic Care is the same as Acute Care; and also adequate home nursing, to encourage home health care, and mental well-being.

Under Education, continuing professional education, including public schools, provider seminars, public media/schools, update on hazard information, attitudes for public and professional to keep them contemporary.

Under Mental Health, accessibility, education, aftercare, crisis prevention, and institutionalization are the priorities for the State. 3

Substance Abuse includes education of abusers, professionals, and the general public, direct service thresholds, coordination with judicial systems, control availability of drugs, including regulation of prescription drugs.

Under Prevention, we discussed the need to assess priorities, provide leadership role and enforcement measures, legislative action and coordination, and education.

Under Statistics and Monitoring, the State has the responsibility to maintain on-going records and statistics of a variety of issues in health care; needs to make sure it is vital, presented in a reasonable format, avoiding duplication, and insuring timeliness of statistics.

Concerning Research, the State has the responsibility for continuation and distribution relative to Montana.

Legal and Medical Interface was another priority we felt the State needs to pay attention to and that there is a need for more professional communication and a need to address the constant need for research.

The final category of State attention is toward Third-party Payers to encourage insurance companies to offer adequate reimbursable allowances. 4

3 The SHCC would identify the quality of institutional care as a responsibility of the State. Deinstitutionalization remains as the policy of the State.

4 The SHCC supports the statement but would include the idea that not only adequate reimbursement is necessary, but adequate inclusion of all necessary health services.

b. Under subquestion b. What is Montana's responsibility for services to the general population, the indigent, the elderly, and other special groups? our group chose not to identify individual subgroups but to consider that all subgroups, all people of the State, deserve an adequate level of service. And so, at a policy level, we arrived at the need to:

(1) Identify individuals truly in need; that is, those with no immediate foreseeable means to pay for the necessary basic health care services (as was also stated in the general policy statement);

(2) Target high-risk groups and delivery of services to needy within those groups;

(3) Assure that there is a vehicle of delivery that is efficient and effective over the long run as well as immediately;

(4) Assure accessibility to systems, with special attention given that certain groups have trouble accessing the system.

GROUP II ISSUE

Where are health services in Montana located and is there need for more local services or relocation of services?

a. In the determination of whether or not a community should have a specific health service, what factors should be used?

-- medical need
-- economic considerations
-- convenience
-- community spirit and identity

b. *Should the State subsidize or assist by other means the development and maintenance of rural health services and facilities? Or transportation to regional health services?*

c. *Should State licensing of health care facilities and services be limited to encourage regional distribution and avoid development of excess capacity?*

-- Certificate of Need *-- other means*

GROUP II REPORT

POLICY STATEMENT:

Overall, general health care services in Montana are appropriate. Some reallocation of services to rural areas along with coordination of existing services is needed. Alternatives to present services should be considered. 5

There are, however, limited resources for health care. Therefore, it is imperative that communities begin the planning process by identifying and prioritizing their health care needs. The State should help this process with input on available funding and resource limitations. Also, programs legislated must have dollars fully allocated to support services they want provided.

a. *In the determination of whether or not a community should have a specific health service, what factors should be used?*

Out of an expanded list of factors, each participant, limited to two choices by the facilitator, then prioritized those factors, and their strong preferences were:

-- availability of alternatives
-- proper utilization of existing services
-- economic consideration

The expanded list included:

-- medical need
-- convenience
-- availability of personnel
-- quality assurance
-- utilization
-- economic consideration
-- community spirit
-- effective transportation
-- alternatives

b. *Should the State subsidize or assist by other means the development and maintenance of rural health services and facilities? Or transportation to regional health services?*

The group divided this question into existing services and expanded services. They felt the present level of rural health services and Emergency Medical Services transportation is appropriate and the continued implementation of those programs should be encouraged. 6

In Emergency Medical Services and the expansion of services, the State's role should be one of the encouragement of services by the private sector, volunteers, and local government. It was felt that it was the State's responsibility to provide these services only as a last resort. 7

c. Should State licensing of health care facilities and services be limited to encourage regional distribution and avoid development of excess capacity?

Question c. was limited by the facilitator to the Certificate of Need process. There was clearly a majority/minority opinion.

Majority opinion: 8

-- *There was a consensus that the Certificate of Need process is necessary but needs structural improvement. Areas that need to be addressed are:*

Shortened appeal process;
The ability to say NO;
The depoliticizing of the process;
Reevaluation of thresholds; and
The possibility that Certificate of Need requirements be applied equally across providers.

Minority opinion:

-- *The Certificate of Need program, with its inherent delays, increases costs to the consumer. The free enterprise system should be stressed. Certificate of Need should be abolished and the free market place allowed to determine services.*

5 The SHCC believes a more accurate statement would be that, "Health care services in Montana are adequate." The next two sentences in the first paragraph then follow more logically.

6 The SHCC believes the issue of adequacy should have been addressed as well as appropriateness. Emergency Medical Services transportation is probably not adequate in all parts of the State.

7 This group did not address the issue of non-emergent transportation to medical care. That issue should be studied further.

8 The SHCC endorses the concept of the Certificate of Need process and in general supports the majority opinion. Particularly important are:

(a) Designing the program to Montana's needs, not Federal requirements;

(b) Increase thresholds beyond those currently in place;

(c) Cover facilities and equipment of all providers equally, not just hospitals and nursing homes.

GROUP III ISSUE

What is the individual citizen's responsibility for his/her health and health care?

a. *To what extent should State and local government be involved in disease prevention programs?*

   -- *sanitation*
   -- *disease screening*
   -- *immunization*
   -- *health education*

b. *To what extent should State and local government be involved in influencing individual life-style to promote health?*

   -- *provision of education*
   -- *funding of local health education services*
   -- *technical assistance to community, business, and labor groups*

c. *Should health promotion activities be evaluated only on their economic aspects? Do Montanans want health promotion services for their personal benefit regardless of whether health dollars are saved in the long run?*

d. *Should healthy life-styles be rewarded through the health care financing system?*

   -- *reduced health insurance premiums*
   -- *deductibles and co-payments*
   -- *refunds for non-smoking, non-drinking, non-overweight, or non-users of service*

GROUP III REPORT

POLICY STATEMENT:

The individual should be responsible for those areas of his/her health that he/she has control over.

Those issues of health that are beyond his/her control may be addressed by State and local government.

An individual's efforts to assume responsibility for his/her health should be augmented by health professionals, information, and education providers

whose actions can contribute to the increased understanding and de-mystification of health matters.

a. To what extent should State and local government be involved in disease prevention programs?

State and local government presently play a limited but vital role in disease prevention and should continue to in conjunction with other interested parties.

Current programs include an immunization program, alcohol and other chemical dependency services and limited screening programs, some in cooperation with local profit and non-profit groups.

Recommendations include:

(1) Strengthen legislation on existing immunization laws so that it is not as easy to waive participation in program (first priority).

(2) Provide effective screening services to general public, in a setting such as health care fairs where general education and prevention information is available. Health care fairs can be best planned by including members of all interest areas--physicians, pharmacists, nurses, health educators, consumers, and other licensed care providers (second priority). Concern has been expressed regarding consumer fraud and quackery.

(3) There is a need for accurate current information and education for the general public on wellness and disease prevention. One option to consider may be coordinating the interest and resources of the State agencies, such as the MSU Extension program and the Department of Health and Environmental Sciences. Concern has been expressed about conflicting statements from State agencies; i.e., the endrin issue. To address this issue, a single point of accountability should be considered to address these issues.

9 The SHCC considers this to cover two areas where the individual may not be able to provide for himself. Health care could be beyond his/her financial resources or could involve environmental or public health issues.

b. To what extent should State and local government be involved in influencing individual life-style to promote health?

A healthy life, or wellness, is a concept comprised, in part, by the elements of mental well-being, physical well-being, personal responsibility, and the environment. State and local government may become involved in programs promoting healthy life-styles, but personal and community responsibility remain as most critical elements.

Keeping in mind the integration of all aspects, the following are categories discussed and suggested programs. The order listed reflects no priorities.

Mental Well-being

- *Stress, exercise, and nutrition management.*
- *Community social programs.*
- *Crisis Centers.*
- *Outreach programs and early identification of problems.*
- *Locally provided services.*
- *Effective school and community programs that include a team approach with emphasis on the issue of self-esteem and worth.*

Physical Well-being

- *Exercise.*
- *Family education.*
- *Consumer education.*
- *Screening clinics (as mentioned in Question a.)*

Personal Responsibility

Includes personal awareness, accurate information, motivation, commitment, and knowledge and acceptance of risks and consequences as well as willingness to be intervention agent and responsibly use public money (Medicaid) when necessary.

Areas of government influence may be to:

- *Strengthen laws requiring personal responsibility for consequences of action (such as DUI).*
- *Stimulate and/or begin model work place programs.*

Environment

State and local government may take some role in safeguarding air quality to insure health.

c. *Should health promotion activities be evaluated only on their economic aspects? Do Montanans want health promotion services for their personal benefit regardless of whether health dollars are saved in the long run?*

The evaluation of health promotion activities is a continuous process, beginning with the initiation of the idea through program design, development, implementation, and evaluation of results. Some of the recommended evaluation criteria include (listed in priority order):

Examining end result.

- *Comparing beginning and ending points over a significant test period.*
- *Individual awareness.*

- *Improvements in life-style and quality of life.*
- *Accomplishment of stated goals.*

Analysis of overall cost versus value including examination of the impact on total health delivery system.

Community demand, support, and utilization.

Duplication avoided.

Personal financial commitment shown by clients.

The group felt that this whole issue required further discussion.

d. *Should healthy life-styles be rewarded through the health care financing system?*

The health care financing system may reward healthy life-styles, but the most equitable and long-term means need further study. Approaches may include:

Reductions or rebates through insurance policies to non-smokers, accident-free clients, and healthy life-style practitioners (those filing no claims during a specified period).

Taxes on health-impacting products such as tobacco and liquor. Concern was expressed regarding government conflict of interest; e.g., tobacco subsidy.

Examination of government regulations that prohibit financing flexibility.

Other health financing concerns include investigation and reevaluation of Federal regulations, specifically FTC regulations and Certificate of Need, and also the reimbursement system.

Exploration of health care systems that foster competition; e.g., HMO's.

GROUP IV ISSUE

Should government take action to control medical costs?

a. *Should there be established rates for Medicaid and other government-financed services rather than reimbursing for costs or charges?*

b. *Should rates for services be regulated with all payers (private, private insurance, Medicare, Medicaid) required to conform to the established payment rate?*

c. *Are Medicaid rules discouraging abuse and inefficient use of services?*

-- ambulance
-- emergency room
-- inpatient vs. outpatient services

What changes should be made if abusers and inappropriate use are problems?

d. *As a general policy, which of the following should be used to help control State expenditures for health if all desired services cannot be covered by available resources?*

-- limit eligibility for Medicare/Medicaid
-- require co-payments from service recipients
-- institute some form of regulation of service charges by hospitals, nursing homes, physicians, etc.
-- rely on market forces with Medicaid/Medicare recipients required to pay the difference between charges and government payments
-- other alternatives

e. *Are there actions the State can take to provide incentives to hold down health care costs by:*

-- the public
-- hospitals
-- nursing homes
-- insurance companies
-- other health professionals
-- physicians
-- State government
-- public health services
-- dentists

GROUP IV REPORT

ISSUE: (Question revised as follows)

To what extent should government be involved in the controlling and/or influencing of health care costs?

POLICY STATEMENT:

That it should be the intent of Montana State government to direct the provision of quality health care services within the limits of health care budgets, considering the maintenance of standards and equitable costs. We give particular emphasis, and the group strongly feels that this goal can be achieved through:

Peer review for all health services; 10
Prospective reimbursement; 11
An examination of eligibility requirements for Medicaid and education of recipient responsibilities;
Prevention and education programs; and

EMPHASIZE:
That the State correlate provided services, that are either legislated or provided in some other fashion, with available money. In

other words, that the State manage its money in a little more effective manner.

MINORITY VIEW: 12

That we really did not focus on cost containment; that our focus, due to the structure of the questions and the way that they were put together, focused primarily on reimbursement kinds of questions.

10 The SHCC considers peer review the key item in accomplishing the objectives outlined in this section. Peer review is already in place in much of our health care system and should be enhanced and expanded.

11 The SHCC recommends that prospective reimbursement should apply to all providers.

12 The SHCC disagrees with the minority view. The issues addressed in this report are important for State government involvement in health care cost containment.

Subquestions:

a. Should there be established rates for Medicaid and other government-financed services rather than reimbursing for costs or charges?

Yes, the majority of the group favors a prospective reimbursement system. 13

b. Should rates for services be regulated with all payers required to conform to the established payment rate?

Consensus: Yes, with emphasis on establishment and implementation of the rates; and peer review.

Other concerns expressed: that rates be consistent from town to town.

Consensus: Recommended for further study the following criteria:

Make Medicaid an insurance program;
Emphasis on prevention, i.e., immunization, prenatal care;
Establish rate-setting authority; this authority should be independent of providers and of State government.
Establish a maximum allowable cost for participation in Medicaid and control payments by private;
Make Medicaid reasonable; 14
Peer review by all providers; education regarding economics of health care.
Quicker reimbursement turnaround time should be implemented to providers.

We also recommended that the State look into other models of regulation throughout the country, and further that in the examination of other models, that the State be asked to look for areas of applicability and areas of non-applicability. Temper rate regulation to account for the kind of emotional response by the general public in the implementation of such a system.

c. Are Medicaid rules discouraging abuse and inefficient use of Services?

Consensus: No.

13 As in the general policy statement, all providers should have a prospective reimbursement.

14 The SHCC considers this to mean that Medicaid coverage should be more consistent over various types of services.

RECOMMENDATION:

We, the group, believe that there is misutilization but that that misutilization is widely and generally dispersed among the population and is not specific to Medicaid situations. We would recommend that the State identify and examine the following actions in terms of whether they could be implemented and implemented effectively; we are basically making a recommendation for further study oriented around these points.

Misutilization is generally dispersed;
Identify abusers; re-educate them;
Examine alternatives to long-term care;
Look at establishment of regulations to provide incentives for cost control by providers;
Educate local social workers regarding appropriate use of health care systems;
Expansion of co-insurance or deductible concept on limited basis;
Examine long-term care rules that discourage efficient use;
Look at alternatives to ambulance services within communities.

e. Are there actions the State can take to provide incentives to hold down health care costs by:

INCENTIVES:

<u>The public</u>:

Tax incentives to keep handicapped and elderly at home (estimated $25,000 savings);
Tax incentive for families to support elderly in facility (tie to eligibility);
Education in proper use of health care system.

<u>Hospitals</u>:

Make Medicaid an insurance program with specific benefits, i.e., inpatient services limited to 20 acute care days per year;

Limit visits and include co-payment feature;
Implement swing beds;
Peer review of hospital procedures;
Reduce State regulations as appropriate;
Eliminate reimbursement for inpatient hospital services when nursing home beds are available.

Nursing Homes:

Intensify discharge plan; more aggressive use of State's 20-day leave program;
Consider a system for respite care;
Better pre-admission screening; identify type of care;
Temporarily license swing beds for personal care.

Insurance Companies:

Insure free market;
Research health risk reduction.

Other health professionals (home health, private mental health counselor, chemical dependency counselors, nurse practitioners, etc.):

Peer review of supportive services;
Look at eligibility;
Pay somehow for better case management, i.e., consulting basis.

M.D.'s

Support across-the-board peer review;
Provide incentives to do work in least expensive setting.

State Government:

Regional planning;
Reduce benefits: correlate provided services with available dollars;
Streamline regulations;
Examine budget criteria;
Examine claims processing mechanism to reduce turnaround time for reimbursement;
Explore preventive service approaches;
Inventory services, facility needs by county;
Provide explanation of benefits to recipients.

Dentists:

Mandate fluoridation of public water supplies (pop. 5,000+);
State-supported (pass through to counties) school-based education, screening and mouth rinse program;
Communicate on peer review, with dentists represented on State review programs;
State support dental access program (reduced fees for elderly).

15 The original group IV report contained sub-group reports. Since these were merged into the policy statement and sub-issue items by the facilitator, they have not been reproduced here.

GOVERNOR'S CONFERENCE

ON

MEETING MONTANA'S HEALTH CARE NEEDS

Participants

Group 1

Facilitator: John Harris
Counseling and Educational Development
Service, Inc.

David Briggs
State Council of Community Mental Health Centers

John Drynan, M.D.
Montana Department of Health and Environmental Sciences

Lolly Evans
Montana Licensed Practical Nurses Association

Hollis K. Lefever, M.D.
Montana Medical Association

Sister Michel Pantenburg
Montana Hospital Association

Don Pizzini
Montana Health Care Association

Tom Sellars
Montana Department of Institutions

Penny States
Montana Farm Bureau

Larry Thomas
Indian Health Service

Ruth Vanderhorst
Montana Nurses Association

Michael Welsh
Montana United Indian Association

Jack Whitaker
Montana Association of Counties

Wade Wilkison
Low Income Senior Citizens Advocate

Group 2

Facilitator: Andy Hudak
Counseling and Educational Development
Service, Inc.

Ben Broderick
Montana Health Care Association

William R. Burke
Montana Association of Local Health Officers

George M. Fenner
Montana Department of Health and Environmental Sciences

Robert Froisness
Montana Department of Social and Rehabilitation Services

John W. Heizer, M.D.
Montana Medical Association

Jerry Hoover
Montana Department of Institutions

Dale Jessup
Montana Hospital Association

Betty Lou Kasten
Montana Health Systems Agency Subarea Council (Eastern)

Joan-Nell MacFadden
Montana Mental Health Association

Helen McGregor
Montana Health Systems Agency Subarea Council (Southwestern)

Howard Purcell
Montana Chamber of Commerce

Judy Rose
Montana Nurses' Association

Louise Oman Salo
Governor's Advisory Council on Aging

Nancy Scheetz-Freymiller
Montana Power Company

Group 3

Facilitator: Candace Crosby
Counseling and Educational Development
Service, Inc.

Frank J. Davis
Montana State Pharmaceutical Association

Sandra Ekberg
Montana Farmers Union

Lois Ferrell
Montana Health Systems Agency Subarea Council (Northwestern)

Monte Gagliardi
Cooperative Extension Service, MSU

Thomas Gillespie
Montana Hospital Association

Edna J. Hinman
Montana Girls State

Bob Johnson
Montana Association of Counties

John W. McMahon, M.D.
Montana Foundation for Medical Care

Robert Moon
Montana Department of Health and Environmental Sciences

Mike Murray
Montana Department of Institutions

Hal Rawson
Montana Blue Shield

Bill Seabrook
Montana Blue Cross

Shirley Thennis
Montana Nurses' Association

Bette Tolson, R.N.
Mountain Bell

Lowell Uda
Montana Department of Social and Rehabilitation Services

Group 4

Facilitator: Dennis Duncan
Counseling and Educational Development
Service, Inc.

Bob Anderson
Montana Department of Institutions

Rolland Arnold
Montana Nurses' Association

John Bartlett
Montana Department of Health and Environmental Sciences

Alan F. Cain
Montana Blue Shield

Wm. Haggberg, D.D.S.
Montana Dental Association

Sterling R. Hayward, M.D.
Montana Medical Association

Ben Johns
Montana Department of Social and Rehabilitation Services

William E. Leary
Montana Hospital Association

Gerald F. Leavitt
Montana Hospitals Rate Review System

Page Puckett
Montana Health Care Association

Mary Ellen Robinson
Montana Health Systems Agency Subarea Council (North Central)

Thomas E. Schneider
Montana Public Employees Association

Dick Simpkins
Mutual of Omaha

Carl Tanberg
Montana Blue Cross

Janice Treml
Montana Association of Home Health Agencies

Cal Winslow, Representative
Montana House of Representatives, Public Health Committee

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**Vice Chairman

TED SCHWINDEN
GOVERNOR

State of Montana
Office of the Governor
Helena, Montana 59620

March 24, 1983

Representative J. Melvin Williams, Chairman
Statewide Health Coordinating Council
State Capitol
Helena, Montana 59620

Dear Chairman Williams:

I want to take this opportunity to thank you and the members of the Health Coordinating Council for your contribution in establishing a dialogue on Montana's health care needs. The 1982 Governors' Conference on meeting Montana's health care needs serves an example of how a broad cross-section of Montanans can come together to discuss and plan ways to improve the future of health care.

I commend you and the council members for initiating a critically important process. State government will continue to support efforts to keep our health care system responsive to people needs in a strong, effective and cost-conscious way.

Sincerely,

TED SCHWINDEN
Governor

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